**DPHHS-MA-098A** (Rev. 01/2008)

**State of Montana**
**Department of Public Health & Human Services**
**Medicaid Services**

# ELECTRONIC BILLING AGREEMENT

(Provider Name) _____ (Billing ID) _____

(Provider Street Address) _____ (City, State, Zip Code) _____

The undersigned provider hereby elects to submit claims by electronic means to the Montana Department of Health and Human Services medical assistance programs in accordance with the provisions stated herein.

The provider agrees that this election does not in any way modify the requirements of the policies and procedures for services, the Montana Medicaid Provider Enrollment Form or any other contract or agreement with the Department, except as to claim submission methods.

Amendments must be in writing and must be signed by the authorized representative of the contracting parties. This agreement shall not be verbally amended.

The provider and the department agree that each party to this agreement shall have the right to unilateral termination of their agreement upon delivery of written notice of termination of the other party.

The provider and/or his intermediary shall provide, upon the request of the state, supportive documentation to ensure that all technical requirements are being met. Examples of supportive documentation include, but are not limited to, program listing, tape dumps, flow charts, file descriptions, accounting procedures and the like.

The provider shall continue to be ultimately responsible for the accuracy and truthfulness of all medical assistance claims submitted for payment. Nevertheless, the provider, if he selects a data processing agent to submit medical assistance claims directly, authorizes the agent to act for the provider to submit claims on the provider's behalf. The provider acknowledges that their agent's submission of the provider's medical assistance claims to the department is on the provider's behalf, and the provider is responsible for the truth, accuracy, and completeness of the claims submitted.

The provider agrees to submit to the Montana Department of Public Health and Human Services or its authorized agent, upon request, sufficient documentation to substantiate the scope and nature of services provided for those claims submitted and for which reimbursement is claimed.

The provider shall provide all documentation requested during the course of a federal or state audit or investigation, concerning the nature, scope or existence of the services pertaining to a medical assistance claim. Should the provider fail to provide such documentation, the provider shall remit to the department the amount previously paid pertaining to the claim for which documentation has been requested. Should such remittance to the department not he made within thirty (30) days after a written demand is made therefore, the department is hereby authorized by the provider to deduct that amount from any amounts which may otherwise be due or become due to the provider.

Requirements for retention of source documents are as follows:

If claim information is transmitted to the intermediary by paper, either the intermediary or the provider must maintain the documents transmitted in accordance with department rules for records retention. Microfilm or microfiche copies may be maintained in place of original documents provided they meet the requirements defined in the Montana Records Management Policies and Procedures.

If claim information is transmitted electronically to the intermediary, the intermediary must maintain the tape, microfilm or microfiche containing the claim information in accordance with department rules for record retention.

The provider acknowledges that the following provider's certification statement, under which he endorses warrants in payment of medical assistance applies to all services he provides regardless of the method of submission to the Department of Public Health and Human Services:

I understand "That Endorsement" hereon or deposit to the accounts of the within named payee is done with the understanding that payment will be from federal and state funds and that any false claims, statements or documents, or concealment of a material fact may be prosecuted under applicable federal and state law.

The provider certifies that the services billed for will have been provided without regard to race, color, national origin, creed, sex, religion, political ideas, marital status, age or handicap.

The provider agrees to furnish to the department's claim processing agent copies of the written agreements with any intermediary that has been authorized to submit medical assistance claims in the provider's behalf.

The provider agrees that billing services and compensation for such will be related to the cost of processing the billing and acknowledges that it may not be related on a percentage or other basis to the amount that is billed or collected and may not be dependent upon the collection of that payment required by federal regulation or this agreement.

The provider agrees that any intermediary that has been authorized to establish receivables and make collections in their behalf shall have an effective system for identifying duplicate payments from other sources (third party) so as to ensure the Montana Department of Public Health and Human Services medical assistance programs' standing as the payor of last resort.

The provider agrees to require any intermediary they contract with to process medical assistance claims to send to the provider, at least monthly, a complete listing of claims processed in their behalf by the intermediary that identifies, at a minimum, the following: 1) patient name, 2) patient medical assistance ID number, 3) date of service, 4) service/procedure, 5) charged amount, 6) all payments,* 7) payment sources.* [Required only when an intermediary is contracted to establish receivables and make collections.] The provider agrees to personally review these reports.

All specifications set forth in the departments, "Electronic Billing Specifications," as from time to time amended, shall be met for every entry submitted. A copy of such procedures may be requested at anytime from ACS Provider Relations. The department agrees to supply the provider with any amendments to these specifications within a reasonable time prior to the time such amendments or changes to the procedures shall go into effect.

It is expressly understood that the department may reject an entire submission at any time for failure to comply with the "Electronic Billings Specifications" as in effect pursuant to the above paragraph or for any other valid reason.

The provider agrees to the obligation of researching and correcting any and all claim discrepancies caused by the provider or their contracted intermediary.

The provider understands that participation in the Montana medical assistance program(s) is subject to compliance with this agreement and Federal and State laws and regulations. Non-compliance is cause for termination of this agreement.

Signed this _____ day of _____, 20__

_____
(Provider Signature)

Distribution: Original to ACS EDI Gateway, Inc., ATTN: EDI Enrollment Unit; 2324 Killearn Center Blvd.; Tallahassee, FL 32309. Fax: 850.385.1705
Copy retained by Provider